

EAP STAFF DEVELOPMENT OPPORTUNITIES

| First Name | Last Name | E-mail | Department | Phone Number |
|------------|---------------------|-------------------|-------------------------------|--------------|
| | | | | |
| | Number of Attendees | Training Location | Projector/Laptop Availability | |
| | | | | |

Select the type(s) of training(s) you are requesting. Each class is for one hour.

| | | | |
|--------------------------|--|--------------------------|--|
| <input type="checkbox"/> | Alcohol and Substance Abuse | <input type="checkbox"/> | Dealing with Difficult Personalities |
| <input type="checkbox"/> | Anger Management | <input type="checkbox"/> | Understanding Signs and Symptoms of Suicide |
| <input type="checkbox"/> | Preventing Workplace Violence | <input type="checkbox"/> | Work Life Balance |
| <input type="checkbox"/> | Stress Management Strategies | <input type="checkbox"/> | Conflict as an Opportunity |
| <input type="checkbox"/> | EAP Essentials | <input type="checkbox"/> | Understanding Mental Health and Mental Illness |
| <input type="checkbox"/> | Assertiveness In the Workplace | <input type="checkbox"/> | Other _____ |
| <input type="checkbox"/> | Defining Acceptable Workplace Behavior | | |

RECOMMENDED CLASS SIZE: Preferred 15-25 & Maximum of 60 unless indicated

Please check the preferred times and days for your training. The EAP team will make every effort to meet your request based on schedule allowance.

| | | | | | | | | | | |
|-----------------|--------------------------|-------------|--------------------------|---------|--------------------------|-----------|--------------------------|----------|--------------------------|----------|
| Time Preferred: | <input type="checkbox"/> | 8:00 AM | <input type="checkbox"/> | 9:00 AM | <input type="checkbox"/> | 10:00 AM | <input type="checkbox"/> | 11:00 AM | <input type="checkbox"/> | 12:00 PM |
| | <input type="checkbox"/> | 1:00 PM | <input type="checkbox"/> | 2:00 PM | <input type="checkbox"/> | 3:00 PM | <input type="checkbox"/> | 4:00 PM | | |
| | <input type="checkbox"/> | OTHER _____ | | | | | | | | |
| Day Preferred: | <input type="checkbox"/> | Monday | <input type="checkbox"/> | Tuesday | <input type="checkbox"/> | Wednesday | <input type="checkbox"/> | Thursday | <input type="checkbox"/> | Friday |

Please complete and return this form to:
employeeassistanceprogram@houstontx.gov

We recommend you submit this form thirty (30) days in advance. Your form will be reviewed within 2-3 business days of receipt and you will be contacted. Thank you for your commitment to change and growth.

Be Well,

The EAP Team

For office use only

Receipt Date:

Training Date:

Confirmation Date:

Approval:

Training Time:

Facilitator:

